Hand In Hand HOSPICE

Chaplain Referral Form

Patient Name:

Does Patient or Family Want Hand In Hand Hospice Chaplain to visit

☐ **No** ☐ **Yes**

Does Pt Currently have Spiritual Support from another Source No ☐ Yes ☐

If Yes, Where is support coming from _____

_____

_____

Spiritual Strengths:

☐Involvement in religious groups ☐Acceptance of prognosis ☐Personal faith experience
☐Sense of purpose in life ☐Belief in rituals ☐Available spiritual support
☐Belief in life after death

Comments:_____
_____

Best Person to Contact Regarding Patient:

Name: _____ Relationship _____

Phone: _____

Names of Admission and On-Going Staff (RN & MSW) _____

_____

Concerns or Issues for Chaplain to be aware of:

_____

_____

_____

_____

_____

Staff Signature:	**Date:**